# SECTION 4
# CODES AND LIMITATIONS

## ALL CHILDREN

✏ Assessment – Insight (90801)
- no PA is required
- maximum of 6, 30-minute units per rolling year
- allowed per provider

✏ Assessment – Interactive (90802)
- no PA is required
- maximum of 2, 30-minute units per rolling year, submit with progress notes
- allowed per provider

✏ Testing (96100)
- no PA required
- maximum of 4 hour units per rolling year

✏ Crisis Intervention (S9484)
- no PA required
- maximum of 6 hour units per rolling year
- additional units beyond 6 require prepayment review, submit with progress notes
- children 0 through 2 year of age require attachment of progress notes with claim

## AGES 0-20

✏ Individual Therapy (90804/90806)
-maximum of 1 procedure per day, additional units not allowed
-5 procedures per month
-additional units beyond 5 per month require prepayment review

✏ Family Therapy (90846/90847)
-maximum of 2 units per procedure per day, additional units not allowed
-10 units per month
-additional units beyond 10 per month require prepayment review

✏ Group Therapy (90853)
-maximum of 3 units per day, additional units not allowed
-15 units per month
-additional units beyond 15 per month require prepayment review

**NO CHANGE IN POLICY FOR LCSW and LPC:**

✏ Family Therapy Without the Patient Present (90846)
-PA required for all children 0 through 20

✏ Children Age: 0 through 2 (90804/90806/90847/90853)
-PA continues to be required for individual therapy, family therapy with the patient present and group therapy

**Note: Services provided while the patient is hospitalized will not require PA nor count toward above monthly/yearly limits.**

**NEW POLICY FOR PSYCHOLOGIST ONLY:**

- Family Therapy without patient present (90846)
  - PA no longer required
  - Certificate of Medical Necessity (CMN) or progress notes must be included with claim for all children 0-20

- Children age: 0-2 (90804,90806,90847,90853)
  - PA no longer required
  - CMN or progress notes must be included with claim for individual, family with patient present and group therapy.

**The use of a CMN does not negate the need for progress notes being included in the client's file.**

# PRIOR AUTHORIZATION

- Services which require prior authorization are:
  Family therapy without the patient present when done by LCSW or LPC
  ALL therapy services for children under the age of three when done by LCSW or LPC.

- Prior authorization must be requested and approved prior to the start of service. A disposition letter will be sent to the provider with a status indicator of:
  A - approved
  I - incomplete
  D - denied
  If the disposition letter status is an I or D, the PA request must be corrected and resubmitted with the appropriate documentation.

- An initial prior authorization request must be accompanied by a treatment plan outlining the frequency, duration, and scope of the services requested, short term goals, long term goals, and a discharge plan. Services can be prior authorized for up to 180 days.

  A prior authorization request for subsequent service must include an updated treatment plan as described above and progress notes of at least the last three (3) visits.

- All prior authorizations are sent directly to Verizon Information Technologies, P.O. Box 5700, Jefferson City, MO 65102 with the exception of services furnished by an employee of Department of Mental Health (DMH) Authorized Agent. Those providers should follow the instructions furnished by DMH.

- The Family Support Division (FSD) (formerly Division of Family Services), does not authorize services but may make referrals. Providers are expected to comply with policies and procedures established by FSD for the documentation and reports required for individuals in their care and custody. Referrals made by FSD does not negate the need for prior authorization according to Division of Medical Services (DMS) policy.

# INDIVIDUAL TREATMENT PLAN

**RECIPIENT NAME:** _____

**RECIPIENT MEDICAID NUMBER (DCN):** _____

**ICD-9CM DIAGNOSIS CODE AND DESCRIPTION**

**PRIMARY:** _____

**SECONDARY:** _____

**PROGNOSIS:** _____

**PRESENTING PROBLEM DESCRIPTION AND PSYCHOSOCIAL INFORMATION:**

_____

_____

_____

_____

**FREQUENCY:**

_____

_____

_____

**DURATION:**

_____

_____

_____

**TREATMENT PLAN CONTINUED FOR:** _____

**RECIPIENT MEDICAID NUMBER (DCN):** _____

**SCOPE:**

_____

_____

_____

**SHORT TERM GOALS:**

_____

_____

_____

**LONG TERM GOALS:**

_____

_____

_____

**DISCHARGE PLAN:**

_____

_____

_____

_____

**NOTE: ATTACH ADDITIONAL SHEETS AS REQUIRED. INDICATE NAME AND DCN ON EACH PAGE.**

## DOCUMENTATION REQUIREMENTS

Reimbursement for each date of service requires all of the following documentation in the patient's medical record:

- The specific services rendered;
- The date and actual time taken to deliver the services; (e.g. 4-4:30 p.m.)
- The setting in which service was rendered;
- The pertinence of the service to the Treatment Plan;
- Identification of other agencies working with the client;
- Plans for coordinating services with other agencies;
- Identify medications which have been prescribed for the individual;
- Client's progress toward the goals stated in the Treatment Plan (progress notes).

**These requirements do not replace or negate documentation/reports required by the FSD for individuals in their care or custody. Providers are expected to comply with policies and procedures established by FSD.**

## TIME-BASED SERVICE LIMITATIONS

A procedure code representing a measure of time is covered for one (1) unit per day. The provider must choose the appropriate time measure to represent the service furnished.

A unit of service which represents 20-30 minutes must include at least 20 minutes face-to-face with the client. When less that 30 minutes is spent face-to-face with the client, the remainder of the time must be directed towards the benefit of the client, including, but not limited to, report writing, note summary, reviewing treatment plan, etc.

A unit of service which represents 45-50 minutes must include at least 45 minutes face-to-face with the client. When less than 50 minutes is spent face-to-face with the client, the remainder of the time must be directed towards the benefit of the client, including, but not limited to, report writing, note summary, reviewing treatment plan, etc.

Providers may not bill a combination of any psychotherapy codes that have the same description, except for time, on the same date of service. For example a half hour of 90804 and 45-50 minutes of 90806 is not covered on the same date of service.

Providers may not bill a combination of time measured psychotherapy codes with a code including a medical component. For example 90804 and 90805 are not covered on the same date of service.

Certain services include a medical component and are not billable by a psychologist, LCSW, or LPC. These codes are: 90805, 90807, 90811, 90813, 90817, 90819, 90824, 90827, 90862, 90865, 90870 and 90871.

Certain services are not covered when provided by a LCSW or LPC and may not be billed for an adult or child when furnished by an LCSW or LPC in any setting. These codes are 90899, 90880, 96100, 96105, 96111, 96115.

**FAMILY THERAPY** (90846/90847)

Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When family therapy without the patient present (90846) or family therapy with the patient present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session. If family therapy is directed at more than one member of the family, the provider is limited to one unit per day, and may focus on different members of the family as needed during the session. Treatment of family members (adults) is not covered when provided by an LCSW or LPC. Family therapy furnished by an LCSW or LPC, must be directed exclusively to the treatment of the child. Parental issues may not be billed.

A psychologist may bill for services provided to an adult. When a family consists of a Medicaid/MC+ eligible adult and child(ren) and the therapy is not directed at one specific child, services may be directed to the adult for effective treatment of the family unit to address the adult's issues and impact on the family. If the adult is not eligible and the family therapy is directed to the adult and not the child, the service may not be billed using the child's DCN.

If there is more than one eligible child and no child is exclusively identified as the primary recipient of treatment, then the oldest child's DCN must be used for billing purposes.

A family may be biological, foster, adoptive or other family unit. A family is not a group and **providers may not submit a claim for each eligible person attending the same family therapy session.**

**GROUP THERAPY** (90853)

Group therapy must consist of a group oriented process delivered to 3 but no more than 8 individuals who are not members of a family. Currently the CPT definition is not time limited and DMS defines a unit of service as a half-hour. A maximum of 3 units per day is covered. Additional units per day are not allowed. A maximum of 15 units per month is allowed; however, additional units beyond the 15 per month may be covered but require prepayment review.

Group therapy may not be billed on the same date of service as family therapy (90846 or 90847) unless the recipient is inpatient, in a residential treatment facility or custodial care facility. Group therapy in a group home is billed with POS-14. Group therapy in a residential/custodial facility is billed with POS-33. Group therapy in a shelter type setting is billed with POS-99.

**DIAGNOSIS CODES**

The diagnosis code must be a valid ICD-9 diagnosis code and must be mental health related. This does not include mental retardation. The only valid codes for the psychology/counseling program are 290-316, V11-V118, V154-1542, V17-170, V40-V401, V61-V619, V624, V628-V6289, V673, V710- V7102, and V79-V791.

The diagnosis code V20.2 is the only valid diagnosis code for a partial Healthy Children and Youth (HCY) screening.

**SCHOOL BASED SERVICES**

When services are provided on public school grounds, the provider must enroll with a pay-to of the school district in which the school is located. A Missouri Medicaid provider number is required for each school district where services are being provided. The only appropriate place of service for a public school setting is 03 and must be used. Services provided in a private school setting must be billed with POS-99.

# MODIFIERS

Effective for dates of service November 01, 2003 and after claims must be submitted using the appropriate modifier(s). The specialty modifier is always required.

| | |
|---|---|
| AH - psychologist | AJ - licensed clinical social worker |
| UD - licensed professional counselor | U8 - in home (12) or other (99) |

# PROCEDURE CODES FOR LCSW AND LPC

The procedure codes listed below are the only counseling codes billable by an LCSW or LPC. The appropriate AJ or UD must be used for all codes.

| Procedure Code | Modifier | Maximum Allowed | Maximum Quantity | Description |
|---|---|---|---|---|
| 90801 | | $24.00 | 6 | Assessment |
| 90801 | U8 | $29.00 | 6 | Assessment-home/other |
| 90802 | | $24.00 | 2 | Assessment-interactive(intac) |
| 90802 | U8 | $29.00 | 2 | Assessment-interactive-home/other |
| 90804 | | $24.00 | 1 | Individual 20-30 mins |
| 90804 | U8 | $29.00 | 1 | Individual 20-30 mins- home/other |
| 90806 | | $48.00 | 1 | Individual 45-50 mins |
| 90806 | U8 | $58.00 | 1 | Individual 45-50 mins- home/other |
| 90810 | | $24.00 | 1 | Intac Indiv 20-30 mins |
| 90810 | U8 | $29.00 | 1 | Intac Indiv 20-30 mins- home/other |
| 90812 | | $48.00 | 1 | Intac Indiv 45-50 mins |
| 90812 | U8 | $58.00 | 1 | Intac Indiv 45-50 mins-home/other |
| 90816 | | $24.00 | 1 | Indiv hosp 20-30 mins |
| 90818 | | $48.00 | 1 | Indiv hosp 45-50 mins |
| 90823 | | $24.00 | 1 | Intac Indiv Hosp 20-30 mins |
| 90826 | | $48.00 | 1 | Intac Indiv Hosp 45-50 mins |
| 90846 | | $24.00 | 2 | Family w/o Patient |
| 90846 | U8 | $29.00 | 2 | Family w/o Patient-home/other |
| 90847 | | $24.00 | 2 | Family w/ Patient |
| 90847 | U8 | $29.00 | 2 | Family w/ Patient-home/other |
| 90853 | | $10.00 | 3 | Group Therapy |
| S9484 | | $48.00 | 6 | Crisis Intervention, hour |
| S9484 | U8 | $53.00 | 6 | Crisis Intervention, hour-home/other |

# PROCEDURE CODES FOR PSYCHOLOGISTS

The procedure codes listed below are the only counseling codes billable by a psychologist. The AH modifier must be used on all codes.

| Procedure Code | Modifier | Maximum Allowed | Maximum Quantity | Description |
|---|---|---|---|---|
| 90801 | | $30.00 | 6 | Assessment |
| 90801 | U8 | $35.00 | 6 | Assessment-home/other |
| 90802 | | $30.00 | 2 | Assessment-interactive(intac) |
| 90802 | U8 | $35.00 | 2 | Assessment-interactive-home/other |
| 90804 | | $30.00 | 1 | Individual 20-30 mins |
| 90804 | U8 | $35.00 | 1 | Individual 20-30 mins- home/other |
| 90806 | | $60.00 | 1 | Individual 45-50 mins |
| 90806 | U8 | $70.00 | 1 | Individual 45-50 mins- home/other |
| 90810 | | $30.00 | 1 | Intac Indiv 20-30 mins |
| 90810 | U8 | $35.00 | 1 | Intac Indiv 20-30 mins- home/other |
| 90812 | | $60.00 | 1 | Intac Indiv 45-50 mins |
| 90812 | U8 | $70.00 | 1 | Intac Indiv 45-50 mins-home/other |
| 90816 | | $30.00 | 1 | Indiv hosp 20-30 mins |
| 90818 | | $60.00 | 1 | Indiv hosp 45-50 mins |
| 90823 | | $30.00 | 1 | Intac Indiv Hosp 20-30 mins |
| 90826 | | $60.00 | 1 | Intac Indiv Hosp 45-50 mins |
| 90846 | | $30.00 | 2 | Family w/o Patient |
| 90846 | U8 | $35.00 | 2 | Family w/o Patient-home/other |
| 90847 | | $30.00 | 2 | Family w/ Patient |
| 90847 | U8 | $35.00 | 2 | Family w/ Patient-home/other |
| 90853 | | $12.50 | 3 | Group Therapy |
| 90880 | | $8.00 | 1 | Hypnotherapy |
| 90885 | | $24.00 | 1 | Psych eval of records |
| 90899 | | Man Price | 1 | Unlisted Psych code |
| 96100 | | $60.00 | 4 | Testing |
| 96100 | U8 | $60.00 | 4 | Testing- home/other |
| 96105 | | $35.00 | 1 | Assess of aphasia |
| 96111 | | $35.00 | 1 | Developmental testing, extended |
| 96115 | | $35.00 | 1 | Neurobehavior status exam |
| S9484 | | $60.00 | 6 | Crisis Intervention, hour |
| S9484 | U8 | $65.00 | 6 | Crisis Intervention, hour- home/other |

## HCY SCREENINGS

Effective with date of service October 16, 2003, the HCY screening code W0025 is no longer a valid code. Developmental/Mental Health Partial Screens are billable by a psychologist, LCSW or LPC with the new codes. These screening codes do not use the AH, AJ, or UD modifiers, instead the codes must have a 59 modifier and if the child is referred on for further care, a UC modifier. The diagnosis code V20.2 is the only valid diagnosis code for a partial Healthy Children and Youth (HCY) screening.

| Proc. Code for Svc. Dates prior to 10-16-03 | Modifier | Proc. Code for Svc. Dates after 10-16-03 | New Modifier 1 | New Modifier 2 | Fee |
|---|---|---|---|---|---|
| W0025 | XE | 99429 | 59 | | $15.00 |
| W0025 | XF | 99429 | 59 | UC | $15.00 |

***Modifier "UC" must be used if child was referred for further care as a result of the screening. Modifier "UC" must always appear as the last modifier.***

# ADJUSTMENT REQUESTS

**REFER TO SECTION 6 FOR ADDITIONAL INFORMATION REGARDING SUBMISSION OF ADJUSTMENTS**

- Utilize the adjustment request form when a claim pays incorrectly (e.g., one unit paid and two units should be paid.
- Only paid claims can be adjusted. Unpaid claims must be corrected and resubmitted.
- Adjustments must be filed within eighteen months of the remittance advice where the claim paid.
- Adjustments cannot be processed if the difference in the payment is less than four dollars.
- Attach a copy of the remittance advice and claim to the adjustment request.

Adjustment transactions will appear on the remittance advice so there will be data history. **DO NOT** attempt to send a check for an overpayment.